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URETHRITIS AS SEEN THROUGH THE URETHROSCOPE

Discussion of the Addresses by Dr. F. C. DOBLE and Dr. A. CAMBELL.

COLONEL L. W. HARRISON: I do not think I have very much to add to what has been said. I would like first to express the pleasure I have had in listening to both papers. Captain Doble has given a very detailed and complete description of the appearances through the urethroscope and the conditions to be found, and I knew well beforehand we should hear something new of Dr. Cambell's wonderful ingenuity in devising instruments. I endorse everything that has been said about the value of the urethroscope. I have heard various remarks about it—that the urethroscope should be in the dustbin, and so forth—but it seems to me that as we are given eyes with which to see, we ought to use them, and that it is just as reactionary to refuse to look down the urethra as it would be to refuse to look at a patient's mouth and throat.

I should like to ask Captain Doble if he could give us an idea of the sort of percentage in which a number of the very interesting conditions he has described occur, because I feel sure that some of us have never seen a number of those he has mentioned, and it would put things into the right perspective if we had some idea of their relative frequency.

I was very glad that Dr. Cambell raised the question of the danger of air embolism. I have heard of cases, and it is well that everybody using the urethroscope should know of the risk. I remember the case at Codford, and I am bound to admit that I was rather responsible for the idea that the gas which was found in the vessels was probably due to a gas-forming organism. I might be excused for having that view, because in the post-mortem report it was stated that gas or air was found in the internal mammary artery; the post-mortem examination

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was carried out on a hot day in May, rather more than twenty-four hours after the death. Afterwards, when I heard of the symptoms which preceded death, and also of other cases, I had to admit I was probably wrong in thinking that the post-mortem appearances were due only to a gas-forming organism. It has been suggested that the risk of an air embolism might be avoided if oxygen were used instead of air. Possibly oxygen would be absorbed and not give rise to the mechanical difficulties arising from a free gas in the circulation.

One other thing I should like to mention is a very good tip given to me by Dr. Gordon, of Vancouver, who is another Dr. Cambell in his ingenuity. He suggested that instead of passing the urethroscope in the ordinary way, that is to say, first to the triangular ligament with the mandrel inserted, one should introduce it with the mandrel to just beyond the fossa and then use air distension as the pilot for the rest of the journey. The idea is that, if one passes the urethroscope the whole length of the canal before commencing to examine, one changes the appearances by smearing the wall of the canal with lubricant, whereas by examining from meatus to triangular ligament one sees the mucous membrane before it has been touched by any instrument. I have commonly used this method myself, and I think it has an advantage over the ordinary method, but I would be chary of using it in a stricture case, as it is in such that there is the greatest risk of air embolism.

Dr. E. HARRISON (Hull) : I am afraid I am very much handicapped to-night, as I have not heard what has been said hitherto.

I think perhaps it would be well if I said something about my own experiences in regard to the urethroscope. Ever since my student days I have been fond of "scopes," and I took to the urethroscope twenty-five years ago. I believe there are people who do not believe in the use of the instrument ; I think it is because they do not take the trouble to learn to use it. You must be able to treat a complaint very much more intelligently with it than otherwise.

The urethroscope I have used for twenty-five years is of the simplest kind. When I first started the clinic at Hull I got more urethroscopic work, and I took to using some other instrument, and was very delighted with the

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wonderful views one got by dilating the urethra, and it seems to me that in operating, if one can get a binocular vision, you judge very much better. It was very difficult to judge where the end of the instrument was, and I went so far as to have an instrument made which provided binocular vision, but I never used it for a reason you will see presently. I think something might be done for those people who like dilating, and a better instrument than mine could be made. I had a terrible experience at that time. I had three deaths with the urethroscope, and I could not find the cause. In all three cases they were people on whom I had passed the urethroscope before; they had each had the urethroscope passed at least a week previously, and in each case the symptoms were the same, or at least in two of them. The patient had an epileptic fit, which lasted twenty minutes to half an hour, and then he died. Nothing was found on post-mortem; a very careful post-mortem was made, and the brain was sent to a London pathologist, without obtaining any satisfactory result. In another case, after a fit, the patient died. After that experience I never did any more dilating. In practice one gets quite as good results without dilating. You do not get the beautiful picture, but you see a little at a time, and are able to operate quite satisfactorily. My instrument is in the simplest form and has no accessories for dilatation. The light is reflected down the tube by a prism. Most of the instruments I use for the work I made myself.

With regard to the treatment of strictures, of course one would think the urethroscope ought to be very valuable, and so it is. Latterly I have not used it so much for strictures. We get a good many of them, because since the V.D. Clinic was established in Hull most of the strictures are saddled on to the V.D. Department instead of the infirmary. I found that a very satisfactory instrument is the sound which tapers from a very fine point up to 3 to 4—I think it is Miller's. If one cannot get through the stricture by means of Clutton's sound, one seldom fails with the graduated sound.

Dr. T. J. WRIGHT, of Norwich, asked if tuberculosis of the urethra had ever been known to lead to strictures. He had seen a case of a boy of seventeen, who had three strictures—plainly seen with the urethroscope—no history or signs of gonorrhœa, but tubercle bacilli were found in

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the urine. From their appearance the strictures seemed to be of long standing.

Another case was a boy of eighteen with a very tight stricture and no history or signs of gonorrhœa.

Secondly, in connection with Dr. Cambell's paper, air embolism had been mentioned, and he thought he remembered Mr. Wyndham Powell pointing out that, when it occurred during urethroscopy, it was nearly always during the examination and treatment of strictures. In view of this, he merely *examined* the stricture under air inflation, and then removed the instrument and passed a Luy's urethroscope down to the stricture. He had found it fairly easy to pass a filiform bougie in this way, and at the same time avoid the risk of air inflation during the operation.

He asked if anyone had tried this method.

Mr. V. E. LLOYD: There are one or two conditions seen in the urethroscope which have not been mentioned. I often speak of them as pitfalls, the first being the sub-mucous hæmorrhage produced by rather rough passage of the urethroscope. That one sees in the floor of the bulbous urethra, and the appearance is of a plum colour. The appearance reminds one more of an angioma. Some of them form rapidly and progress to quite a large size, and if one is not quite sure of the condition one is liable to increase it very much by keeping the tube in that position. Other conditions worth mentioning are the congenital abnormalities of Cowper's ducts; the commonest is a dilatation of the opening of the duct. The commonest type is when the two ducts unite in a depression 2 or 3 mm. in size, which looks like an ulcer or a false passage. Another condition is a congenital cystic dilatation of one of the ducts themselves. The orifice is usually not seen, but the duct is considerably enlarged and stands out rather like a sausage. That is generally taken for a cyst. You get out some serous secretion, which fills up again very often in a week.

Colonel Harrison was asking a short while ago as to percentages or statistics of uncommon growths in the urethra. The only variety of which I can speak is the polypus. I had a series of thirteen cases of polypi found in the floor of the prostatic urethra. These cases were taken from 2,600 cases of gonorrhœa, which works out at $\frac{1}{2}$ per cent.

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In connection with the passage of filiform bougies through the urethroscope, I have not been able to pass them on some occasions. But I am not able to say it is of great advantage to use the urethroscope for the passage of the bougies, because in the usual type of cases so often the stricture is an extremely small one, and as soon as the bougie enters the stricture its lumen is hidden and the bougie tends to stick at that point. That applies to a stricture of some length, and not to a short stricture.

In connection with tubercular disease of the urethra, I have seen two cases, both of which were terminal conditions. The case I can remember most clearly was associated with tuberculosis of one kidney, and also of the bladder. There were gross lesions of the ulcerated type in the prostatic urethra, and there was no contraction whatever and no impression of a stricture. The general teaching is that a tuberculous lesion of the urethra is almost always a terminal condition, and it is unlikely to proceed to the formation of a stricture, because it does not heal and is generally fatal.

The CHAIRMAN (to Mr. Lloyd): I think you have some photographs.

Mr. LLOYD: There are seven radiographs of gonococcal spurs on view. The cases all present the same symptoms and give a history of gonorrhœa spread over four to eight years. All these cases in that time have had several recurrences of gonorrhœa, and they have all suffered from gonorrhœal rheumatism. The spurs seem to arise in three or four years. The spur starts in the well-known condition of "painful heel." In the early stages no bony lesion can be detected by X-rays. After a time you can find the fully developed spur, as shown in some of the photographs. Once you get a well-marked spur the only adequate treatment is excision of the spur.

Dr. CAMBELL: Might I ask if an acknowledgment might be sent to the Holborn Surgical Instrument Company for the loan of the instruments?

The CHAIRMAN: Yes.

Dr. DOBLE: Some of the questions were evidently on my paper, and some on my colleague's. One looks up the cases in the literature, and one finds that a mistake made a thousand years ago is repeated in the text-books.

As Mr. Lloyd says about the polypi, which is one of the commonest conditions in the urethra, the percentage is

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$\frac{1}{2}$ per cent. In the Royal College of Surgeons there are some twenty beautiful specimens.

As to the rarer conditions, these must be excessively rare. I have only seen a very few. I have seen tubercular ulcerations on three or four occasions. I have seen primary, secondary, and tertiary syphilis. I have never seen sarcoma. I have seen herpes.

With regard to air embolism, I think the idea of oxygen is a very good one. I was very interested in Colonel Harrison's description of Gordon's examination of the urethra. Mr. Wyndham Powell is a great believer in this method, and had extraordinary good results.

With regard to Dr. Harrison, of Hull, I am glad he agrees with us. We want a binocular urethroscope, and also some means of throwing what one sees on to a screen, because it is otherwise impossible to show the condition to anyone else.

With regard to Dr. Wright's question of tubercular ulcerations, I have only seen one case, in a small boy. In his case there was a fibrous ulcer. This condition can cause stricture.

With regard to the boy of eighteen, I did not mention the condition of the ducts. I have seen some extraordinary-looking objects, like cysts in some cases.

As to the hæmorrhage, this is usually due to carelessness in putting in the tube.

Dr. CAMBELL : As regards Colonel Harrison's suggestion of oxygen instead of air for distending the urethra, it seems to me that in air embolism, where death has taken place, it has been brought about by the mechanical effect of a large quantity of air on the heart, so that probably a sufficient volume of oxygen would have the same effect.

No doubt the binocular urethroscope would be a great advantage, as it would afford stereoscopic vision, but there are many mechanical difficulties in the way. Stereoscopic vision would be most useful in those cases of obstruction where the true opening is at a higher level than the stricture, which is illustrated in the drawing I have shown you. In this case the false passage appeared to go down to below the fibrous band. With the binocular instrument one would be able to appreciate the different levels.

Dr. Wright mentioned the examination of stricture and in passing a filiform without air pressure. The air,

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of course, can be shut off, but obviously it is not so easy to see the opening through the stricture as when the urethra is fully distended.

Mr. Lloyd said he had difficulty in passing the pilot through the stricture. My answer to this must be that probably he was not in the true opening. As I said before, there may be two or three openings through the stricture, and it may be difficult to distinguish the real one.